Large Jails and Communicable Disease:

An Update on

"Why Public Health Must Go to Jail"

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Beginning in the 1970s, disease information specialists (DIS), the street-level, public health trackers of sexually transmitted diseases (STDs), began to note a significant number of individuals identified as STD patients in local jails. Several of these specialists by the late 1990s occupied key public health roles at the local, state, and federal levels. From these positions, they were able to direct the focus of public health agencies toward jails as important facilities where they could screen for and potentially treat not only STDs, but also a variety of other communicable diseases.

On finding rates of STDs in jails ranging from 2 to 35% of the inmate population, most public health workers recognized the need to prioritize working with corrections and the community to stop the cycling of disease in and out of the jail. The HIV/AIDS and hepatitis C (HCV) epidemics and tuberculosis (TB) outbreaks in jails and prisons called greater attention to the public health/public safety nexus and to the critical roles jails can play in preventing the spread of communicable diseases.

Chicago Meeting Generates Blueprints for Change

Representatives from the 18 largest jail systems in the United States met in Chicago in October 1999 to explore ways public health departments and jail systems could work together to address communicable disease issues (Krane and Miles, 2000). Teams from each of the cities/counties represented at the meeting were composed of sheriffs, jail administrators, correctional health administrators, and HIV, STD, and TB directors from the local and state health departments where the jails were located. Presentations and discussions centered on state- and community-specific information about communicable diseases and the need for corrections/public health collaboration. Each team developed a "blueprint for change" focusing on specific goals for public health/corrections collaboration and a plan to implement the blueprint over the following 2 years. A follow-up plan was presented to track progress and partici-

pants' perceptions of success, barriers, and facilitators for the blueprints developed at the meeting.

Most of the blueprints developed by the 18 jurisdiction teams involved disease screening/counseling and testing (n = 8), linkages with community providers, discharge planning, case management (n = 6), and disease-related educational programs for inmates addressing STDs and/or AIDS (n = 2). At the time of the follow-up interviews, most of the participating jurisdictions reported at least some progress toward meeting the objectives outlined in their blueprints. In some jurisdictions the original plans had shifted once the team returned home. For example, some jurisdictions decided that it would be more advantageous to provide disease-related educational programs to inmates than to attempt a disease screening program.

A report by Abt Associates, the contractor selected by the Centers for Disease Control and Prevention (CDC) to conduct the follow-up survey and interviews, detailed the "themes, challenges, and strategies" involved as the jurisdictions attempted to implement their blueprints. Five "contextual factors" were found to affect the success of the blueprints, as perceived by the participants:

- The bureaucratic complexity of the organizations involved provided both benefits (e.g., effective division of labor with clear communication) and barriers (e.g., multiple levels of responsibility in health departments that led to unclear lines of communication between health and jail officials).

- Jails and health departments with prior experience of working together had a greater likelihood of perceived success in their outcomes.

- Having a "champion" within collaborating agencies increased the likelihood of success, unless that person left the agency without a championing successor.

- Rapid turnover of jail inmate populations remained a key barrier to the perceived success of a project. Several jurisdictions overcame this difficulty by focusing on post-conviction inmates who remain in the jail for longer periods of time.

- Finally, if there had been a precipitating event, such as a disease outbreak, which had forced health and jail staff to work together prior to the meeting, the success of the blueprint was enhanced. (See Hammett, 1998, for a similar analysis of collaboration issues in prison and jail settings.)

Abt also identified six implementation factors, issues that arose while jurisdictions were putting the blueprints into action and that affected the perceived success among the participants:

- In some jurisdictions it was necessary for jail and public health personnel to think of each other in different ways than they had in past relationships, effectively changing the way they did business together.

- The different missions of corrections and public health (at least as perceived by some) had an impact on how successful this shift was in different communities.

- Ongoing conflict between and within some participating agencies affected how the plan developed and was enacted in some places.

- In other jurisdictions, the realities of the local situation led to a change in the goals and plans. What had seemed reasonable at the planning table was not feasible when participants returned to the facility (such as harm reduction strategies that did not fit into jail operations).

- Turnover among the planning team members and the addition of new team members back in the community affected the implementation and/or direction of the project in some locales.

- The ability to involve community-based organizations (CBOs) in implementing some of the plans proved difficult in several areas, leading to changes in the plans.

Availability of funds at the local level to implement the plans also affected what evolved in several of the participating jurisdictions. Perhaps the most interesting finding in the follow-up survey was that the programs that were actually initiated required no significant additional monies. By working collaboratively, the agencies were often able to identify existing resources to solve the identified problems.

In spite of the challenges presented by various contextual and implementation factors, only two of the 18 jurisdictions failed to implement some version of their plan. The sponsoring organizations received very few requests for technical assistance from the jurisdictions during the follow-up period, suggesting that local teams were able to tackle the implementation successfully on their own. Screening, counseling, and testing programs, as well as linkages to CBOs all increased in the participating cities and counties following the conference.

New Partnerships Support the Effort

Another outcome of the conference was the development of a partnership between CDC and the Health Resources Services Administration (HRSA). This partnership has funded a 5-year, seven-state demonstration project to provide counseling and testing, medical treatment, within-facility discharge planning, and continuity of care into the community for HIV positive inmates. The 12 states with the highest HIV morbidity rates were eligible to apply for these funds, though only seven could be funded. Many of the funded projects operate in jail settings, and some are in both jails and prisons (as well as juvenile detention centers). Some of the Chicago meeting participants, representing jails in Chicago, Atlanta, and New York City, are part of the demonstration project.

Technical assistance for the project is provided by the Southeast AIDS Training and Education Center (SEATEC) and the Hampden County Correctional Center. The National Minority AIDS Council (NMAC) provides technical assistance for the CBOs involved in the project.

Evaluation data are being collected from the projects by the Rollins School of Public Health at Emory University and Abt Associates. (See further information online at http://www.sph.emory.edu/HIVCDP/.) Preliminary data from the evaluation reveal that these collaborative projects are testing more jail inmates and discovering a greater disease burden among the inmates (Arriola, et al., in press).

Next Steps

CDC's goal remains the development of effective jail/public health collaborations to address disease screening, intervention, and prevention efforts based on local need and local expertise. Although a national follow-up conference has not yet occurred, some regional efforts to replicate the Chicago effort have taken place. For example, CDC, HRSA, and Region VI of the U.S. Department of Health and Human Services, Office of Women's Health (serving Louisiana, Texas, Arkansas, Oklahoma, and New Mexico) co-sponsored an August 2001 conference in Dallas titled "Linking Correctional Health with Community Health: Partners in Prevention and Care of Infectious Diseases." From that conference, state-level planning efforts involving both jails and prisons have begun in Louisiana and Texas.

Individual counties in other states have invited CDC to assist them in developing public health partnerships with jails and juvenile detention centers. These are often the result of participation in the syphilis elimination program being led by CDC. Law enforcement, corrections, and public health officials are becoming more aware of the vital role jails can play in controlling and preventing communicable diseases, if they are properly funded and involved in the planning process.

Jails are not public health agencies, but they can play a major role in enhancing public health in their communities by partnering with local health departments. Twenty years ago the underpinnings of community policing were not viewed as "proper" policing, but community policing now constitutes a major policing philosophy. The situation with regard to the partnership between jails and local public health agencies is at the same stage that community policing was two decades ago. Through the leadership and models provided by jails in the Large Jail Network, we believe the public safety/public health nexus will become engrained as part of "best practice" local corrections. We thank those who have been involved to date and look forward to working with other interested jurisdictions. ■

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